

**DEPARTMENT OF INSURANCE
STATE OF ARIZONA**

Financial Affairs Division - Compliance Section
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
Phone: (602) 364-3998
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LIFE CARE PROVIDER ANNUAL REPORT – A.R.S. § 20-1807

FISCAL YEAR END	REPORT DUE DATE
12/31/2023	03/15/2024
12/31/2024	03/15/2025
12/31/2025	03/15/2026
12/31/2026	03/15/2027
12/31/2027	03/15/2028
12/31/2028	03/15/2029
12/31/2029	03/15/2030
12/31/2030	03/15/2031
12/31/2031	03/15/2032
12/31/2032	03/15/2033
12/31/2033	03/15/2034
12/31/2034	03/15/2035
12/31/2035	03/15/2036
12/31/2036	03/15/2037
12/31/2037	03/15/2038
12/31/2038	03/15/2039
12/31/2039	03/15/2040
12/31/2040	03/15/2041
12/31/2041	03/15/2042
12/31/2042	03/15/2043
12/31/2043	03/15/2044
12/31/2044	03/15/2045
12/31/2045	03/15/2046
12/31/2046	03/15/2047
12/31/2047	03/15/2048
12/31/2048	03/15/2049
12/31/2049	03/15/2050
12/31/2050	03/15/2051
12/31/2051	03/15/2052
12/31/2052	03/15/2053
12/31/2053	03/15/2054
12/31/2054	03/15/2055
12/31/2055	03/15/2056
12/31/2056	03/15/2057
12/31/2057	03/15/2058
12/31/2058	03/15/2059
12/31/2059	03/15/2060
12/31/2060	03/15/2061
12/31/2061	03/15/2062
12/31/2062	03/15/2063
12/31/2063	03/15/2064
12/31/2064	03/15/2065
12/31/2065	03/15/2066
12/31/2066	03/15/2067
12/31/2067	03/15/2068
12/31/2068	03/15/2069
12/31/2069	03/15/2070
12/31/2070	03/15/2071
12/31/2071	03/15/2072
12/31/2072	03/15/2073
12/31/2073	03/15/2074
12/31/2074	03/15/2075
12/31/2075	03/15/2076
12/31/2076	03/15/2077
12/31/2077	03/15/2078
12/31/2078	03/15/2079
12/31/2079	03/15/2080
12/31/2080	03/15/2081
12/31/2081	03/15/2082
12/31/2082	03/15/2083
12/31/2083	03/15/2084
12/31/2084	03/15/2085
12/31/2085	03/15/2086
12/31/2086	03/15/2087
12/31/2087	03/15/2088
12/31/2088	03/15/2089
12/31/2089	03/15/2090
12/31/2090	03/15/2091
12/31/2091	03/15/2092
12/31/2092	03/15/2093
12/31/2093	03/15/2094
12/31/2094	03/15/2095
12/31/2095	03/15/2096
12/31/2096	03/15/2097
12/31/2097	03/15/2098
12/31/2098	03/15/2099
12/31/2099	03/15/2100

February 28	→→	May 29
September 30	→→	December 29
October 31	→→	January 29
December 31	→→	March 31

(Full and Exact Corporate Name)

(Doing Business As / Or Facility Name)

(Statutory Home Office Address: Street & Number, City, State, Zip Code and phone number)

(Administrative Office Address: Street & Number, P.O. Box, City, State, Zip Code – enter phone numbers below)

Phone No.: () - (8) - Fax No.: () -

NAIC No.(if assigned): _____ Arizona Company No. (if assigned): _____ Fed. ID No.: _____

organized under the laws of _____ on _____
(Month, Day, Year)

as a ☐ Non-Profit Corporation ☐ Stock Company ☐ Partnership

() Other (Specify):

hereby submits the attached sixteen (16) items of information and Exhibits thereto, in accordance with A.R.S. § 20-1807.

Dated at _____, this _____ day of _____, 20_____

I hereby depose and certify that I have prepared or reviewed this Report and it is true, complete, and correct to the best of my knowledge and belief.

Signature of Chief Executive Officer ONLY

Type/Print Chief Executive Officer's Name and Title

Subscribed and sworn to before me, this _____ day of _____, 20____

Notary Signature

Stamp or Seal here

My Commission Expires

Type/Print Preparer's Name and Title

Preparer's Phone Number and E-Mail Address

THE FILING FEE REQUIRED FOR THIS REPORT IS \$450.00

PAYMENT OPTIONS – CHECK ONLY ONE OPTION FOR THE METHOD BY WHICH THE REQUIRED FILING FEE HAS BEEN PAID:

- ☐ **ACH DELIVERY** IN ACCORDANCE WITH FORMAT AND CONTENT PRESCRIBED IN FORM E-ACH. INSTRUCTION **SENT**(DATE) _____.
- ☐ **CHECK** PAYABLE TO ARIZONA DEPARTMENT OF INSURANCE ENCLOSED WITH THIS REPORT.

MAIL THIS REPORT TO:

Attention: COMPLIANCE SECTION
ARIZONA DEPARTMENT OF INSURANCE
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269

1. State the name, the address and a description of the physical property of the facility below.

2. a. Make a written *statement* below of the terms and conditions of the life care contracts to be used by the Provider, including the services to be provided to residents pursuant to the contract and the fees or charges to be paid by residents, including the method of payment of the fees or charges.

The life care contract shall provide that any person entering into the contract shall have a period of seven days within which to rescind the life care contract without penalty or further obligation beginning with the first full calendar day following the last to occur of: the execution of the contract, the payment of an initial sum of money as a deposit or application fee, receipt of a copy of the Provider's most recent annual report if the Provider has filed an annual report with the Director of Insurance pursuant to A.R.S. § 20-1807, or, if the Provider has not filed an annual report, a copy of the Provider's application. In the event of a rescission, all money or property paid or transferred by the person shall be fully refunded by the Provider. A person shall not be required to move into a facility until after the expiration of the seven-day rescission period.

- b. Attach a copy of the Life Care Contract as **Exhibit 1**.

3. If the Provider is not an individual, such as a corporation, partnership or trust, make a written *statement* below naming the fiscal year end date that is the last day of a calendar month and the type of legal entity and listing the interest and extent of such interest of each principal in the entity.
4. a. If the Provider is not an individual, list below the names of all members of the Board of Directors, Officers, Trustees, or Managing Partners.
- b. Attach, as **Exhibit 2**, the original signed Arizona Biographical Affidavit Form E110 for EACH person that has not filed an original Arizona Biographical Affidavit Form E110 within the previous 3-year period. A Biographical Affidavit is required immediately on the substitution or installation of a member of the board of directors or an officer, trustee or managing partner different from the information disclosed in the Provider's application. One blank Form E110 is provided in this packet. Please make sufficient supply to distribute to all persons required to file at this time or in the near future. Each Affidavit must be complete for all information requested, and must have an original, notarized signature. Incomplete or improperly executed Affidavits are not acceptable.

NAME

TITLE

DATE OF LAST FILING OF
ORIGINAL AFFIDAVIT FORM E-110

5. (a) The number of residents of the facility to be provided services by the Provider pursuant to the life care contracts.

Number on last day of reporting fiscal year _____

Estimate number on following fiscal year end _____

- (b) The number of living units occupied pursuant to the life care contracts.

Number on last day of reporting fiscal year _____

Estimate number on following fiscal year end _____

- (c) The number of residents of the facility to be provided services by the Provider under **contracts other than life care.**

Number on last day of reporting fiscal year _____

Estimate number on following fiscal year end _____

- (d) The number of living units occupied pursuant to **contracts other than life care.**

Number on last day of reporting fiscal year _____

Estimate number on following fiscal year end _____

6. Make a written *statement* below of the provisions that have been made or will be made to provide reserve funding or security by the Provider to enable the Provider to fully perform the Provider's obligations pursuant to life care contracts, including the establishment of escrow accounts, accounts in financial institutions, trusts or reserve funds.

7. Make a written *statement* below as to whether the Provider was or is affiliated with a religious, charitable or other nonprofit organization, the extent of any affiliation and the extent to which the affiliate organization will be responsible for the financial and contract obligations of the Provider.
8. If the Provider is a subsidiary corporation or the affiliate of another corporation, make a written *statement* below identifying the Parent Corporation or the other Affiliate Corporation and the primary activities of the parent or other affiliate corporation.

9. Provide a written *description* below of the business experience of the Provider in the operation of similar facilities and, if the facility will be managed on a day-to-day basis by a corporation or organization other than the Provider, a *description* of the business experience of the manager in the operation or management of similar facilities.
10. Make a written *statement* below as to whether the Provider, a promoter, a principal, a parent or subsidiary corporation, or an affiliate has had any injunctive or restrictive order of a court of record, or any suspension or revocation of any state or federal license or permit, arising out of or relating to business activity or health care applied against it, including without limitation actions affecting a license to operate a foster care facility, a health care institution, a retirement home, or a home for the aged.

11. Make a written *statement* below of any periodic rates to be initially paid by the residents, the method by which the rates are determined and the manner by which the Provider may adjust the rates in the future. If the facility is already in operation, or if the Provider operates one or more similar facilities within this state, the *statement* must include tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous five years or any shorter period as the facility may have been operated by the Provider.

12. Make a written *statement* below of the terms and conditions under which a life care contract may be canceled by the Provider or Resident, including any health and financial conditions required for a person to continue as a resident and any conditions under which all or any portion of the entrance fee will be refunded by the Provider.

13. If construction or purchase of the facility has not yet been completed, make a written statement below of the anticipated source and application of the monies (in financial statement form) to be used in the purchase or construction, including all of the following:
- (a) An estimate of the cost of purchasing or constructing and equipping the facility including related costs as financing expense, legal expense, land costs, occupancy development costs and all other similar costs that the Provider expects to incur or become obligated for before the commencement of operations.
 - (b) An estimate of the total entrance fees to be received from residents on completion of occupancy.
 - (c) A description of any mortgage loan or other long-term financing intended to be used for the financing of the facility, including the anticipated terms and costs of the financing.
 - (d) An estimate of any funds that are anticipated to be necessary to fund start-up losses and to assure full performance of the obligations of the Provider pursuant to life care contracts including any reserve fund escrow required by the Director pursuant to A.R.S. § 20-1806.

14. Attach as **Exhibit 3**, certified financial statements of the Provider, Promoter and Manager **as of a date not more than ninety (90) days before the date the Annual Report is filed, that shall include a balance sheet and the related statements of income, retained earnings or equity and changes in financial position for the two most recent fiscal years** or any shorter period of time as the Provider, Promoter or Manager has been in existence. Each of these statements **shall be prepared in accordance with generally accepted accounting principles** and reported on **by a certified public accountant** in accordance with generally accepted auditing standards. The certified financial statements of the Promoter shall be filed with the Annual Report unless the Promoter is not currently employed by the Provider.

Assets shall be reported at values determined pursuant to A.R.S. §§ 20-511 through 20-515. If the Director of Insurance deems it necessary to value any real estate, the Director may employ one or more competent appraisers for that purpose and the reasonable expense thereof shall be borne by the Provider.

15. Attach as **Exhibit 4**, an actuarial study prepared by a qualified actuary for the purpose of demonstrating that the project has sufficient revenues and funds, including reserves, for the project to continue as a viable operating concern. The actuarial study shall include a cash flow projection, an evaluation of the adequacy of current pricing structures and an analysis of the long-term relationship between the project's assets and liabilities. The Provider shall file the actuarial study on a triennial basis beginning with the year in which resident occupancy began at the facility pursuant to the permit issued to the Provider, or more often as required by the Director of Insurance. If an actuarial study is not filed with this Annual Report, state the date of the last filed actuarial study.
16. Attach as **Exhibit 5**, copies of the escrow agreements executed with an escrow agent pursuant to A.R.S. §§ 20-1804 and 20-1806.

PURSUANT TO A.R.S. § 20-1807(F), THE DIRECTOR MAY ASSESS AND COLLECT A CIVIL PENALTY OF NOT MORE THAN TWENTY-FIVE DOLLARS FOR EACH DAY THE ANNUAL REPORT IS LATE AGAINST A PROVIDER WHO FAILS TO FILE THE ANNUAL REPORT TIMELY ACCOMPANIED BY THE REQUIRED FEE.